

# MONTANA PEDIATRIC FACILITY RECOGNITION CRITERIA

## Montana Department of Public Health and Human Services EMS & Trauma Systems Section, Emergency Medical Services for Children and Child Ready Montana

Pediatric emergency patients have unique needs, requiring specialized personnel, training, equipment, supplies, and medications. Deficiencies in these areas have resulted in historically poorer outcomes for pediatric patients versus adults. Since 1985, federally funded Emergency Medical Services for Children (EMSC) programs in each state have been working to improve the quality of pediatric emergency care. The Health Resources and Services Administration require that all EMSC grantees report on specific performance measures. This includes implementation of a standardized system recognizing hospitals that are able to stabilize or manage pediatric medical emergencies and trauma cases.

We describe the steps involved in implementing Montana's Two (2) Level Facility Recognition processes to provide appropriate pediatric care. This criterion is in compliance with new Health Resources and Services Administration performance measures. [Ann Emerg Med. 2009;] and the *Guidelines for Care of Children in the Emergency Department* based on the 2009 Joint Policy Statement in collaboration with the American Academy of Pediatrics (AAP), American College of Emergency Physicians (ACEP), and Emergency Nurses Association (ENA). The Montana Chapter of the American Academy of Pediatrics endorses the Montana Pediatric Facility Recognition Criteria.

Access to optimal emergency care for children is affected by the lack of availability of equipment, appropriately trained staff to care for children, and policies and procedures that ensures timely transfer to definitive care. Although advances have been made that promote access to emergency care for children, improved awareness of the pediatric resources available to hospitals and the development of a coordinated emergency care systems, may optimize access and outcomes for many acutely ill and injured children.

### MONTANA'S PEDIATRIC FACILITY RECOGNITION CRITERIA HAS TWO LEVELS OF RECOGNITION.

Montana's voluntary certification program recognizes hospitals that meet specific criteria for personnel training, equipment, and facilities that support optimal care for ill or injured infants, children, and adolescents.

**PEDIATRIC PREPARED FACILITY** – Pediatric-Prepared Emergency Care, a voluntary program recognizing hospitals that have demonstrated their ability to provide advanced pediatric care for the majority of pediatric medical emergencies including illness and injury. Pediatric-Prepared Emergency Care is a partnership between hospitals, physicians, nurses, emergency personnel and the Emergency Medical Services for Children program at the Montana Department of Health and Human Services EMS & Trauma Systems and Child Ready MT.

**PEDIATRIC CAPABLE FACILITY** – Pediatric-Capable Emergency Care, a voluntary program recognizing hospitals that have the ability to provide limited pediatric care and have a system in place to transfer to a pediatric prepared facility.

FACILITY: \_\_\_\_\_ LOCATION: \_\_\_\_\_

DATE: \_\_\_\_\_

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*Note: The hospital board of directors, administration, medical staff and nursing staff shall demonstrate a commitment to quality pediatric care and shall treat any pediatric patient presented to the facility for care.*

The following table shows levels of PEDIATRIC facility recognition and their essential “E” or desirable “D” characteristics. These Pediatric specific criteria are **IN ADDITION** to the Montana Trauma Facility Designation Criteria.

<b>PEDIATRIC FACILITY RECOGNITION CRITERIA</b>	<b>PEDIATRIC PREPARED FACILITY</b>	<b>PEDIATRIC CAPABLE FACILITY</b>	<b>Being developed</b>	<b>Not initiated</b>
<b><i>FACILITY</i></b>				
Participation in the statewide trauma system including participation in Regional Trauma Advisory Committee; support of regional and state performance improvement programs; and submission of data including pediatric data to the Montana State Trauma Registry.	E	E		
Twenty-four hour coverage availability of the emergency department (ED) shall be provided by at least one physician or mid-level provider responsible for the care of patients including critically ill or injured children.	E	E		
Facility to have the capabilities to consult via Telehealth or Telemedicine with a Pediatric Specialist.	E	E		
<b><i>CARE TEAM</i></b>				
Medical Staff have the necessary skill, knowledge, and training in the emergency evaluation and treatment of Pediatric patients who may be brought to the ED, consistent with services offered by the hospital including resuscitation.	E	E		
Nurses, Midlevel Providers and other health care providers have the necessary skill, knowledge, and training in providing emergency Pediatric care, consistent with the services offered by the hospital.	E	E		
Baseline and annual competency evaluations completed for all ED staff, and include evaluations of skills related to neonates, infants, children, adolescents, and children with special health care needs.	E	E		
Emergency physicians and/or providers have the capability to seek video or telephone consultation with Pediatric Specialists for critically ill and injured children using Tele Health capabilities and/or equipment in the ED.	E	E		
The pediatric nurse coordinator (preferably a registered nurse {RN}) who possesses special interest, knowledge, and skill in emergency care of children. * Can be an LPN, EMT, or other skilled hospital staff*	E	D*		
Include a pediatric component to multidisciplinary committee review functions with a multidisciplinary committee of medical disciplines (including the trauma coordinator) involved in caring for pediatric patients. Required review: all transfers out, all diversions, all pediatric deaths, all child abuse/neglect cases, and pediatric medication errors.	E	E		

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<b><i>POLICY</i></b>				
Required by state law specific Child maltreatment and domestic violence reporting policies including criteria, requirements, and processes.	E	E		
Death of a child in the ED policy.	E	E		
Family-centered care policy including family involvement, presence in patient care and decision-making, medication safety processes, discharge planning/ instruction, and bereavement counseling that is culturally appropriate.	E	E		
Medical imaging policies, specifically addressing pediatric weight-based or age appropriate dosing ALARA (as low as reasonably achievable) principles.	E	E		
<b><i>PREHOSPITAL PEDIATRIC CARE</i></b>				
The program reviews pediatric pre-hospital protocols and policies related to care of the pediatric injured or ill patient.	E	E		
EMS feedback through the performance improvement program regarding pediatric patient care and/or participation (preferred).	E	E		
EMS staff is provided pediatric specific education opportunities and all education is documented.	E	E		
<b><i>INTER-FACILITY TRANSFER</i></b>				
Pediatric specific In-house or transfers guidelines with a higher level of care hospital (both in state and out of state facilities.)	E	E		
Signed inter-facility transfer agreements in place for transfer of pediatric specific population patients to a higher level of care.	E	E		
<b><i>DISASTER PREPAREDNESS</i></b>				
Hospital disaster plan addresses issues specific to the care of children including children with special health care needs.	E	D		
Participation in community disaster drills which include a pediatric mass casualty incident component at least every two years.	E	E		
<b><i>PEDIATRIC PATIENT SAFETY</i></b>				
<b>ALL</b> Children are weighed in kilograms only.	E	E		
Weights are recorded in a prominent place in the ED Record.	E	E		
Use of a standard method of estimating weight in kilograms if a scale is not available (a length-weight based system.)	E	E		
Infants and children have a full set of <b>Admission AND Discharge</b> vital signs recorded ( <b>age appropriate- temperature, heart rate, blood pressure, respiratory rate, Glasgow Coma Scale, and SP02</b> ) in the medical record.	E	E		
Processes for safe medication storage, prescribing and delivery that include pre-calculated dosing guidelines for children of all ages.	E	E		
Pediatric emergency services are culturally and linguistically appropriate.	E	E		
ED environment is safe for children and supports patient and family centered care.	E	E		
Use at least two patient identifiers when providing care, treatment, and services.	E	E		
Pediatric equipment, supplies, and medications are appropriate for children of all ages and sizes, are easily accessible, clearly labeled, and logically organized. Staff are educated on location of all items.	E	E		

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<b>GENERAL</b>				
All Physicians, mid-level Providers, and Nursing staff shall maintain pediatric emergency medicine education every 2 years, including Pediatric Advanced Life Support (PALS) and/or Emergency Nursing Pediatric Course (ENPC). *Unless you are a provider who is Board Certified.	E	E		
Pediatric Specific nursing education: All nursing staff shall have PALS and/or ENPC certification within 12 months of hire.	E	E		
Training is provided for Family-Centered Care (FCC) and Cultural Sensitivity, including involving families in patient decision-making processes; family presence during all aspects of care including resuscitation; education of parents and other caregivers; discharge planning; and bereavement counseling.	E	E		
Pre-hospital providers transporting to the facility shall participate in Pediatric Advanced Life Support (PALS-every 2 years) and/or Emergency Pediatric Course (EPC at least every 4 years.)	E	E		
<b>PEDIATRIC EQUIPMENT AND SUPPLIES:</b>				
Patient warming device	E	E		
Intravenous blood/fluid warmer	E	E		
Weight scale, in kilograms, not pounds for infants and children.	E	E		
Length-based resuscitation tape	E	E		
Age appropriate Pain Scale assessment tools	E	E		
Feeding Tubes (sizes 5 Fr, 8 Fr)	E	E		
Foley Catheter	E	E		
<b>MONITORING EQUIPMENT</b>				
Accurate Temperature Monitoring Device	E	E		
Blood pressure cuffs (neonatal, infant, child)	E	E		
Continuous end-tidal CO2 monitoring device	E	E		
Electrocardiography monitor/defibrillator with pediatric-sized pads/paddles	E	E		
Handheld Doppler ultrasonography devices	E	E		
Pulse oximeter with pediatric probes	E	E		
Glucose monitor	E	E		
<b>RESPIRATORY EQUIPMENT AND SUPPLIES</b>				
Endotracheal tubes (uncuffed: 2.0-3.0 mm; Cuffed/uncuffed- 3.5-8.0 mm)	E	E		
Laryngoscope blades (curved: 2, 3 and straight: 0-3)	E	E		
Laryngoscope handle	E	E		
Oropharyngeal airways <i>Size</i> (0, 1, 2, 3, 4, 5)	E	E		
Magill Forceps (pediatric)	E	E		
Naso/Orogastric Tubes ( 6Fr – 18 Fr)	E	E		
Nasopharyngeal airways (infant and child)	E	E		
Stylets for endotracheal tubes (pediatric)	E	E		
Suction Catheters (Sizes: 6, 8, 10, 12, 14, 16 Fr)	E	E		
Yankauer/rigid Suction Tip	E	E		
Tube Tracheostomy tray with chest tubes ( <i>Sizes</i> 2, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5 mm)	E	D		
King Tube (2, 2.5, 3, 4, 5) if within local use	E	D		

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Bag-mask device (manual), self-inflating (sizes 250 ml & 450 ml)	E	E		
Clear oxygen masks (Standard infant and child)	E	E		
<i>Partial non-rebreather infant</i>	E	E		
<i>Non-rebreather child</i>	E	E		
Masks to fit bag-mask device adaptor ( <i>Neonatal, infant, and child</i> )	E	E		
Nasal cannulas (infant and child)	E	E		
Laryngeal mask airway <i>Sizes 1- 5 (if within local use)</i>	E	D		
Supplies/kit for patients with difficult airway conditions (to include but not limited to supraglottic airways of all sizes, such as the laryngeal mask airway, 2 needle cricothyrotomy supplies.)	E	D		
<b>VASCULAR ACCESS SUPPLIES AND EQUIPMENT</b>				
Interosseous needles AND device (pediatric size)	E	E		
Arm Boards (infant and child)	E	E		
Umbilical vein catheters (Size 3.5 F, 5.0 F)	E	D		
Central Venous Catheters ( <b>any two sizes 4.0F – 7.0 F</b> )	E	D		
Catheter-over-the-needle device (14 – 24 gauge)	E	E		
<b>FRACTURE MANAGEMENT DEVICES</b>				
Extremity splints, including femur splints (pediatric sizes)	E	E		
Cervical/spinal immobilization supplies with age appropriate (infant and child) including semi-rigid collars, backboards, towel rolls, straps, etc.	E	E		
<b>SPECIALIZED PEDIATRIC TRAYS OR KITS</b>				
Chest Tubes: Infant Size 10 F or 12 F	E	D		
Chest Tubes: Child Size 16 F or 18F and 20F or 24 F	E	D		
Newborn delivery kit (including equipment for initial resuscitation, umbilical clamp, scissors, bulb syringe and towel.)	E	E		
Pediatric BAG or Cart w/ defined list of weight-based contents, easily accessed w/ list on outside	E	E		
<b>MEDICINES</b>				
Adenosine	E	E		
Amiodarone	E	E		
Antimicrobials (parenteral and oral)	E	E		
Atropine	E	E		
Calcium chloride	E	E		
Charcoal (activated, with or w/out sorbitol)	E	E		
Corticosteroids	E	E		
Dextrose (D10W, D50W)	E	E		
Dopamine	E	E		
Epinephrine- (1:1000; 1:10,000 solutions)	E	E		
Flumazenil	E	E		
Glucose	E	E		
Lidocaine	E	E		
Magnesium Sulfate	E	E		
Naloxone Hydrochloride	E	E		
Sodium Bicarbonate (4.2%, 8.4%)	E	E		

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<b>RAPID SEQUENCE/DRUG ASSISTED INTUBATION</b>				
Induction agents	E	E		
Paralytic Medications	E	E		
<b>OTHER MEDICATIONS</b>				
Activated Charcoal (with & without sorbitol)	E	E		
Analgesics	E	E		
Anticonvulsants (benzodiazepines, barbiturates)	E	E		
Antidotes (including cyanide)	E	E		
Antipyretics	E	E		
Bronchodilators	E	E		
Corticosteroids	E	E		
Diuretics	E	E		
Insulin	E	E		
Topical, oral and parenteral analgesics	E	E		
Narcotics	E	E		
Ocular Anesthetics	E	E		
Sedatives	E	E		
Vaccines-Tetanus, diphtheria-Tetanus, dPT, Immune globulin	E	D*		
Vasopressor agents	E	E		
<b>QUALITY IMPROVEMENT/PROCESS IMPROVEMENT PROCESSES</b>				
The health care institute shall have an operational Quality and Performance Improvement program that monitors, evaluates, and improves the performance of pediatric patient care on a continuous basis.	E	E		
The QI/PI Plan shall include pediatric specific indicators.	E	E		
Collaboration with existing national, regional and/or state programs for pediatric issues (including but not limited to: asthma, substance abuse screening and intervention, immunization, injury prevention, and child abuse prevention/shaken baby.)	E	E		
Monitor pediatric specific prevention programs.	D	D		
Provide Suicide Prevention and Mental Illness information and referral resources.	E	E		